Community Behavioral Healthcare
Association of Illinois

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Healthcare
Association

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HMPGR
The Path to Transformation
1115 Waiver Concept Paper
CBHA Comments

The Path to Transformation waiver concept paper outlines the states desire to demonstrate:

- "that by spending Medicaid dollars differently, we will have better health outcomes for our Medicaid clients at or below the same costs."
- "Many of the innovations outlined in this concept paper are investments that will help to "bend the cost curve" by eliminating unnecessary costs, reducing rates of institutionalization, and focusing on health and wellness, which will yield a return within the five-year budget window."
- "We must also invest now to build a modern, integrated delivery system that can achieve better outcomes at less cost. Failing to make these investments now may result in short-term savings but longer-term costs in the form of high emergency department and inpatient admissions and poorer health outcomes and population health. To ensure that Illinois is able to make these investments, we are requesting to use a without-waiver trend that is reflective of the national rate of cost growth."

The Path to Transformation waiver concept paper also outlines in broad brush strokes that the state would like to accomplish these objectives through four important "pathways":

1. HCBS infrastructure, choice and coordination. Illinois will rebuild and expand its home and community-based infrastructure, especially for those with complex health and behavioral health needs. We will expand access to and choice of HCBS services for our beneficiaries and ensure that services are based on individual needs and preferences rather than disability.
2. Delivery system transformation. Illinois' healthcare delivery system will be built off of integrated delivery systems (IDS) -- centered around patient-centered health homes -- that are built based on the needs of the patient population. Integrated delivery systems have the ability to employ team-based care practices, accept and disburse payments and financial incentives to providers within their system, and provide performance reports and counseling to individual doctors and practices. IDSs will be held accountable for the health outcomes of individual patients within their networks as well as for their overall patient population. The goal is for IDSs to reduce costs and improve quality through management of care and care transitions and aligned incentives to ensure the right care at the right time in the most appropriate setting.

3. Population management. Illinois will expand the capacity of the healthcare delivery system to take responsibility for the health of a population, with a focus on prevention, primary care and wellness. Population health can also be addressed by helping delivery systems focus on the health of their individual patients as well as on the health of the panel of patients they serve.
4. Workforce. Illinois will build a 21st century health care workforce that that is ready to practice in integrated, team-based settings in geographies and disciplines that are in the greatest demand, including the ability to utilize community health workers and ensure all health professions are able to assume responsibility to the full extent of their education and training.

CBHA General Comments

As referenced in the concept paper the state made significant reductions in its mental health budget in recent years, cutting $114 million in general revenue funding for mental health services between 2009 and 2011. These cuts were in addition to community behavioral health care providers exclusion from incentives for HIT development, chronically late state payments, and Medicaid rates frozen since the turn of the century.

The cuts mentioned in the concept paper and the factors mentioned above leave as referenced in the paper ***"many providers unable to invest in the kinds of systemic change needed to drive long-term cost savings, improved outcomes and improved patient care."***

CBHA applauds the fact that within The *Path to Transformation* waiver concept paper the State wants to develop and implement and achieve additional expansion of capacity in the community and counteract the additional incentive toward institutionalization that is inherent in the state's current nursing facility assessment.

May we also suggest the state would do well to recognize the critical need to maintain the current community behavioral health care services as it focuses on the many moving parts of health care reform including the *Path to Transformation?*

Behavioral health expansion and integration

As community-based services have experienced continuous budget cuts, it has become nearly impossible in Illinois to provide the depth and breadth of acute, chronic, and long-term supports, care, treatment and services that are needed by the Medicaid population with co-morbidities, including mental illness, substance use disorders and chronic health conditions. **We believe that state cannot produce the desired health outcomes - while bending the cost curve for these most expensive clients - without**

- **first maintaining community-based behavioral health care services**
- **and second by developing a safe transition to enhancing these community-based services.**

In addition to our general comments made above as requested we have additional brief comments in the other requested categories under listings A through D as follows.

A) 21st Century Health Care Workforce Workforce: Diversity, Loan Forgiveness and Training

We request that allied health professionals, social workers, interdisciplinary primary and community based team members, including peer counselors be included in the list of "health care professions and workers" that the state prioritizes to improve the diversity of this workforce and for those eligible to receive loan forgiveness and workforce training grants.

B) Delivery System Transformation

1. Current BH care, treatment and services must be maintained under fair compensation.
2. We must ensure waiver strategies, payment practice and infrastructure reform strategies under Health Care inject funds into all 102 counties for the state's community mental and substance use disorder system as we avert the elimination of care to people with the need for specialized intensive community BH care, treatment and services
3. Successful models that address BHC needs in the community require an engagement or intensive community case management fee in addition to fair rates used for Medicaid FFS reimbursement.

C) Build Capacity of the Health Care System for Population Health Management

As it shapes it waiver Illinois has a choice when it comes to their highest utilizers. Individuals with serious mental illness, or children with serious emotional disturbances, have or are at risk of developing chronic complex conditions in addition to their mental illness condition, and as a result need to have access to—or should have access to—a number of clinical services.

Health Homes expands on the Medical Home Model and using Health Homes inclusive of Care Coordination and engagement fees is a solution Illinois decision makers need to grapple with and decide whether to systematically develop Health Homes in order to take on complex BHC cases with health homes inclusive of Care Coordination and engagement fees – or not.

A health home that's required to attend to the needs of complex BHC has implications for how organizationally and programmatically a health home has to operate. Addressing the types of social and other support services necessary for a person is an additional service array issue we will have to be conscious off as we define health homes as a solution including in the crafting of waiver services.

The health home is accountable for all of the health needs of its members.

- That doesn't mean that that health home has to directly deliver all of the services that a person needs.
- It means that Health Homes are accountable for ensuring that that person has access to or is coordinated and connected to those services that that person need
- It also means that health homes role as being accountable to that person's health needs is not just for the people that show up for an appointment, it's for those people who rarely show, or who might only show up in the hospital emergency department that could have been better attended to by engaging routinely in that health home. So what that has implications on is, well, how do you communicate with and engage in outreach to those folks who rarely show?

Patient enrollment and provider assignment is a key barrier, particularly if a health homes program is focused on what has sometimes been called "super users," as individuals who are poorly managed who are using the emergency department as their primary site of care.

See: Financing and Policy Considerations for Medicaid Health Homes for Individuals with Behavioral Health Conditions. April 15, 2013

- New York State has an assignment process in which health home providers are expected to find and engage individuals who they have not served before, and who in some cases are not using any regular source of community-based care.
- NY pays Health Homes 80% of their PMPM for engagement for up to two periods of three months each.

http://www.integration.samhsa.gov/about-us/webinars

D) Home and Community Based Infrastructure, Coordination and Choice

Similar to the concepts papers referenced investment strategies outlined under Hospital/Health System Transformation and Nursing Facility Transformation the state and Community based behavioral healthcare providers would also benefit from support for:

1. Development and implementation of one or more incentive-based pools to drive transformation of systems, including, but not limited to:
    a. care development, quality care improvements, and regional collaborations on state public health initiatives and community needs;
    b. Development of integrated delivery systems, including HIT/HIE infrastructure, governance and care models;
    c. Development, implementation and training on effective transitions of care models;
    d. Technical assistance to support the development of integrated delivery systems that are capable of assuming responsibility for the health care of a defined population;
    e. An access assurance pool to cover uninsured and unreimbursed Medicaid costs to assure access and preserve the "safety net"; Development and implementation of a pool to support debt relief or capital investments for providers that commit to redesigning, downsizing or closing some or all of their facilities, including transformation of rural systems to potentially create rural "hubs"
    f. Debt relief or capital investments for nursing facilities that commit to redesigning, downsizing or closing some or all of their facilities, including technical assistance in developing new business models to retool facilities to meet the needs of emerging populations;
    g. Flexibility to develop and fund additional supportive housing and employment options for those populations in need of long term care, at the appropriate levels.

The state and community based behavioral healthcare providers would benefit from the above referenced investments, investment outlined for Hospital/Health System Transformation and Nursing Facility Transformation as community behavioral health care is essential to bend the cost curve as shown by the following national and Illinois examples.

Examples of bending the cost curve.

NY Chronic Illness Demonstration Project

- 2013 data show clients in the program for at least two years experienced a 45 percent reduction in the number of hospital admissions and a 15 percent decrease in ER visits, compared with two years prior to enrollment.
- Providers were paid a per-patient/per-month case management fee of about $300, with Medicaid paying separately for each beneficiary's standard health care benefits.

Missouri

- 'Health home' initiative shows $4.2M savings in first year
- Savings were in hospital and emergency room Medicaid costs of 19,000 patients Mike Sherry KHI News Service June 25, 2013

Illinois

Comparing SMI Patients who received CMHC services to SMI patients who did not Costs were 13% less with 18% fewer hospitalizations!

	Not in CMHC services	Receiving CMHC services.
Cost	$13,095	$11,390
Hospitalizations	41,209	33,777

Illinois Behavioral Health Home Coalition * Key Observations for individuals in the Coalition's geographic area. * As reported by Heritage Behavioral Health Center Diana Knabe, Decatur Illinois. Data analytics conduced by - Care Management Technologies

Illinois

Screening, Assessment and Support Services (SASS) System is avoiding $19 million in hospitalization and related costs*.

"SASS is estimated to **avoid approximately $19 million per year in costs to the State** for unnecessary psychiatric inpatient hospitalization and related costs."*

***Healthcare and Family Services Annual Report to the Governor FY'13 Report on Community Screening, Assessment and Support Services - the Illinois Children's Mental Health Partnership (ICMHP).**

Illinois

Adult Redeploy.

Since 2011, 10 sites in full implementation have diverted 838 non-violent offenders, or the equivalent of two cellblocks of a prison.

The evidence-based practices utilized by the current sites have been shown by research to reduce recidivism by as much as 20%. ARI also demonstrates significant cost savings while reducing pressure on the system and increasing public safety.

In 2012, sites spent an average of $2,233 per ARI participant, compared to the annual per capita incarceration cost of $21,500 (FY11). Based on the 838 offenders diverted, **this represents $16.1 million in potential corrections savings.***

***2012 Annual Report to the Governor and General Assembly on the Implementation and Projected Impact of Adult Redeploy Illinois**

Redeploy for Youth

Because of the alternative path offered by Redeploy, Redeploy counties have instead committed only 174 youth per year on average since 2006, a 51% reduction, averting millions in annual incarceration costs to the state.

- Federal funding was secured to support a cost-benefit analysis and a recidivism study intended to support statewide expansion efforts and to demonstrate the program's continued effectiveness.
    - Analysis indicates that only 17.4% of youth who successfully completed Redeploy services were arrested on new charges during the period covered by the study, compared to 72.8% of juvenile justice-involved youth not in Redeploy.
    - Further, the rate of re-incarceration among Redeploy participants was 14.2%, compared to 57.4% among non-participants.